SOCIETY OF ACTUARIES

Article from:

In The Public Interest

January 2014 – Issue 9

VALUATION AND PRICING CHALLENGES UNDER THE ACA

By Daniel S. Pribe

Editors' note: This article was written prior to unexpected changes in regulations that may differ from certain information presented in this article.

The Patient Protection and Affordable Care Act (ACA) introduced several components that begin to blur the lines between social and private insurance. These components include the federal advanced payment programs (federal premium and cost-sharing subsidies), and the federal risk mitigation programs, often referred to as the 3Rs (risk adjustment, reinsurance and risk corridors). The intent of these programs is two-fold: first, to make health insurance more affordable for the commercial, individual and small group markets. And, second, to stabilize the markets, as health insurance issuers attempt to value the cost associated with the full implementation of the ACA's required changes in covered population and benefits.

These programs will have an impact on an issuer's pricing decisions, which drive profitability and surplus. The balance of this article provides background on these programs and explores how they may affect an issuer's financial performance.

BACKGROUND ON THE FEDERAL ADVANCE PAYMENT AND RISK MITIGATION PROGRAMS

Following is some background on the 3Rs and the advanced payment programs.

The 3Rs

The 3Rs were introduced to stabilize the individual and small group markets as we transition from a "pre-ACA" to a "post-ACA" environment. Risk adjustment, the first of the three, is a permanent program that transfers funds to health insurance issuers that disproportionately attract higher risk individuals and takes funds from issuers that attract lower risk individuals. This applies only to non-grandfathered individual and small group health plans both inside and outside of the Health Benefit Exchanges (HBEs). This is a zero-sum game (i.e., amounts paid to high-risk plans equal the amounts taken from low-risk plans) and requires no additional funds from the federal government.

The transitional reinsurance program is only in place for three years, 2014 through 2016. In 2014, this Health and Human Services (HHS) administered program will pay the insurer 80 percent of an individual member's claims between $60,000 and $250,000. While the reinsurance recoveries are only paid for claims within the non-grandfathered individual market, the reinsurance premium of $5.25 per member per month (PMPM) must be paid by the insurer for all commercial insured and self-insured plans (i.e., excludes Medicaid, Medicare, CHIP, Stop-loss, Military benefits, and tribal coverage). This is also intended to be a zero-sum game, since only the money collected from health insurance carriers will be used to pay the reinsurance recoveries. No additional money from the federal government will be used to fund this program. In fact, if the reinsurance program is overfunded, then HHS will hold these amounts for use in a subsequent year, while if the reinsurance program is underfunded, then HHS will reduce reinsurance payments proportionally among issuers.

The temporary risk corridor program is also in place only from 2014 through 2016 and applies to all qualified health plans (QHPs) in the individual and small group markets. QHPs will be required to share a portion of either their profits or their losses, related to the misestimation of their allowable costs, with the federal government, based on the following thresholds.

Actual Compared to Projected	Payment to/from HHS
Less than 92%:	Issuer pays HHS 2.5% of target plus 80% of difference between 92% of target and allowable cost.
92% to 97%:	Issuer pays HHS 50% of difference between 97% of target and allowable cost.
97% to 103%:	Neither issuer nor HHS pays.
103% to 108%:	HHS pays issuer 50% of excess over 103%.
Greater than 108%:	HHS pays issuer 2.5% of target plus 80% of excess greater than 108%.

CONTINUED ON PAGE 24

Daniel S. Pribe is a director, consulting actuary with Optum in Creve Coeur, Mo. He can be reached at *dan.pribe@optum.com*.

This program is not a zero-sum game because the money paid into the program is not intended to be offset by the money paid out of the program. In other words, the federal government subsidizes the losses, or, conversely, shares in the gains, with each individual insurer.

The risk adjustment and reinsurance calculations will be calculated independently, while the risk corridor calculation is completed only after these two programs are both taken into consideration.

Advanced Payment Programs

The ACA also introduces two advanced payment programs to make health insurance more affordable for those who enroll through an exchange. The federal premium subsidy will sometimes provide tax credits to individuals in households where combined income is less than 400 percent of the Federal Poverty Level (FPL). The amount of the subsidy is a function of the individual's household income relative to the FPL. However, in states that choose not to expand Medicaid, individuals below the FPL will NOT qualify for any tax credits to offset their insurance premiums (and they may not qualify for Medicaid, either).

The federal cost-sharing subsidy, or Cost Sharing Reduction (CSR) subsidy, will reduce cost sharing for individuals with household incomes between 100 percent and 250 percent of the FPL. To qualify for CSR, these individuals must also be enrolled in a silver level individual plan purchased in the Health Benefit Exchange (HBE). Unfortunately, in states that choose not to expand Medicaid, the lowest income (below FPL) individuals do not qualify for this program, and they may also not qualify for Medicaid.

Additional Fees

There are several additional fees introduced by the ACA. The first of these fees is the Health Insurance Provider fee, or excise tax, that an insurer must pay to the federal government. The government will use premiums reported from the previous year to determine the tax. The expected total collection for 2014 is $8 billion, increasing to $11.3 billion in 2015 to 2016, and increasing annually thereafter. This translates to roughly 2.5 percent of premium for a for-profit insurer and half of that for a non-profit insurer.

Another fee is the exchange fee. This fee is 3.5 percent of premium for those insurers that participate in the Federally Facilitated Exchange, but that percentage may vary for those states that have their own exchange. The final two fees are the Patient Centered Outcomes Research Institute (PCORI) fee of $2.00 per member per year (PMPY) and the Risk Adjustment User Fee of $0.96 PMPY.

While these fees aren't a major cost, relative to the first two fees, they clearly impact profitability and could affect surplus and cash flow, depending on the timing of payments.

PROFITABILITY

Now let's take a look at these in the context of the Federal Medical Loss Ratio (MLR), or profitability. The simplified MLR formula is as follows:

$$MLR = \frac{\text{Incurred Claims +/- 3Rs impact + Health Quality Improvement Initiatives}}{\text{Premiums - Federal and State Taxes - Licenses and Fees}}$$

The following observations, in isolation, can be made:

- A low risk score will create a risk transfer payment out of the company, increasing the MLR.
- Reinsurance recoveries will decrease MLR (note that the reinsurance recoveries impact the numerator, while the reinsurance premium adjusts the denominator).
- Increased quality improvement expenses will increase MLR.
- Federal fees, such as the health insurance tax and exchange fees, will increase MLR.

However, the following items cannot be looked at in isolation.

- Low risk scores may also mean lower claims costs, which would offset the risk transfer payment.

- Health quality improvement (HQI) initiatives may decrease claims. If the decrease in claims more than offsets the cost of the HQIs, then the MLR will be lower.

There are also a couple of things to consider outside of this formula. First, consider risk scores. In the Medicare environment, it is very clear that revenue increases as a Medicare Advantage plan's risk score increases. However, this may not necessarily be the case in the commercial market, now subject to the Risk Adjustment calculation. Since the commercial market is a zero-sum game, it is not as clear that increasing risk scores will materially impact revenue. In other words, is there an ROI on an issuer's efforts to improve risk scores, such as a detailed chart audit? Additionally, if an issuer does not ensure the highest level of accuracy in capturing all necessary claims information when calculating risk scores (and everyone else in the market does), then that issuer's risk score may be understated, and that issuer would have to pay out funds to issuers with higher risk scores.

Next, consider pricing. Issuers were required to submit premium rates assuming a neutral risk score; therefore, issuers had to make an assumption as to the average risk of the entire individual or small group market in a state. Some issuers may have priced their products resulting in aggressively (low) priced bronze and silver plans (i.e., benefit plans with an actuarial value of 60 percent and 70 percent, respectively). Other issuers may have priced their products such that their gold and platinum plans (i.e., benefit plans with actuarial values of 80 percent and 90 percent, respectively) were more attractive to purchasers. The expectation is that those with low risk scores will be attracted to the bronze and silver plans, while those with higher risk scores will be attracted to gold and platinum plans.

In order to analyze profitability in these situations, one must consider risk adjustment and reinsurance. Take, for example, a relatively low-priced gold plan. The hope for issuers in this situation is that the risk scores may overestimate the claims associated with respective members. In other words, the risk transfer payment they receive as a result of higher risk scores will more than offset the additional claims these enrollees may incur. Next, let's consider an extreme example where a particular issuer has only enrolled bronze plan members with low risk scores and low expected claims. This issuer will most likely have to pay out a risk transfer payment, due to the relatively lower expected risk score. Additionally, this issuer may have lower than expected reinsurance recoveries because its members will incur lower costs.

SURPLUS AND CASH FLOW

The ACA has created several new accrual items that issuers will need to estimate in their financials. Additionally, the timing of these payments will affect cash flow, which could be a concern for issuers with most of their business within the individual and/or the small group markets.

The first of these accrual items is the risk transfer payment or receivable, depending on an issuer's risk score relative to everyone else in the market. The risk transfer amount will not be due until the following calendar year so the issuer must accrue for this throughout the current year. In addition, the carrier will not have information regarding how their risk compares to that of the state and so may have difficulty in trying to estimate this value.

Issuers must also accrue for the expected amount of reinsurance receivable that they will receive from the federal government. A related item is the amount payable for the reinsurance premium. The premium is also not due to the government until the end of the calendar year, but the issuer must accrue for this payable throughout the year.

The third accrual item is the risk corridor receivable or payable. Sometime during the year, the experience (i.e., MLR) for a product will be estimable. An accrual may be necessary. For example, if an issuer expects an MLR significantly higher than expected, then the risk corridor may

CONTINUED ON PAGE 26

kick in, and the issuer will have to estimate a receivable.

Another, possible, significant accrual item to estimate is the federal CSR subsidy. At the beginning of the year, the issuer must make an assumption of how much cost sharing will be subsidized. The federal government will pay a monthly amount throughout the year to the issuer based on this assumption. A reconciliation payment will be required at the end of the annual period. The issuer must determine an accrual estimate throughout the year to recognize that the actual payment received at the end of the year may be higher or lower than originally expected.

CONCLUDING COMMENTS

Provisions within the ACA that address affordability and market stability create significant profitability and valuation challenges for issuers. Issuers must understand how these programs interact with each other and understand their timing, since they could have significant impact on profitability, surplus and cash flow. Failure to do so could create some unexpected and unpleasant financial surprises for the unprepared.

Social Insurance & Public Finance Co-Editor Position:

This person will assist the editor with oversight of the SOA SI&PF section newsletter called In the Public Interest. Responsibilities include helping to solicit and edit article submissions on topics pertinent to the section. This person will also assist the editor with communicating with the authors regarding edits, timing, etc. The newsletter is published twice a year. SOA staff editor assists the editor and co-editor. Please contact *Jeffery Rykhus at jrykhus@gmail.com* if you are interested in this position.